ARKANSAS

Work Pays APPLICATION

If you need this material in a different format, such as large print, contact your DHHS or DWS local office.
Si necessita este formulario en Espanol, llame 1-800-482-8988

1) Applicant Information -Please complete about yourself. If another parent is in the home, please list in number 2 below.

Social Security Number	Last Name			First Name		MI
Birth Date	Race	Sex	County	E-mail Address		
Street Address				City	State	Zip Code
Mailing Address (if different)				City	State	Zip Code
Home or contact telephone	Work telephone			May we contact you at work? ❑ Yes ❑ No	Fax number	

2) Household

List all children under age 18 living in the household. Please list the other parent if he/she is also living in the home.

Social Security Number	Last Name	First Name	Birth Date	Race	Sex	Relationship to You	U.S. Citizen (Yes/No)

3) Work/Income

Please complete this section about you and the second parent if living in the home.

Source of Income	Y	N	Where?	Gross Pay (Before deductions)	How often?	How many hours per week?
Are you employed ?						
Are you engaged in any other activity such as community service, college work study, Vocational Education or GED?	Y	N	What activity?	Where?	How often?	How many hours per week?
Is second parent (if living in the home) employed?	Y	N	Where?	Gross Pay (Before deduction)	How Often?	How many hours per week?
Do you or other parent in home have any unearned income?	Y	N	Source?	Gross Pay	How often?	Who receives?

4) Question

Have you or any household member been found guilty or nolo contendere(no contest) to a felony conviction involving the manufacture or distribution of a controlled substance? ☐ Yes ☐ No

Personal Responsibility Agreement
Arkansas Work Pays Program

I understand that the Personal Responsibility Agreement (PRA) will provide me with individual responsibilities that I must comply with while participating in the Arkansas Work Pays Program. I understand that this program is limited to twenty-four (24) months and that I must be employed and seeking employment that will increase my pay and enhance career choices. I understand that supportive services will be provided if needed.

I agree to the following responsibilities:

1. Work the maximum number of hours possible up to 40 hours per week, but if I am only able to work 24 hours weekly, I agree to engage in other allowable work activities as required by my Work Pays Case Manager.

2. Accept full time employment that may be offered.

3. Cooperate and work with my case manager in developing my Career Advancement Plan and following the plan activities.

4. Follow up on job leads that would lead to better pay and a possible career.

5. Will not voluntarily terminate employment.

6. Ensure that my children receive their age appropriate childhood immunizations.

7. Ensure that my school age children attend school.

8. Cooperate with the Office of Child Support Enforcement in seeking child support and/or establishing paternity.

9. Report any changes within 10 days that will affect my eligibility.

I understand that in some circumstances the agency may determine that I had good cause for not complying with the above requirements.

Read carefully before you sign this application

- I understand that I must help establish my eligibility by providing as much information as I can and in some situations I may be required to provide proof of my circumstances.
- I authorize the Department of Health and Human Services (DHHS) and Department of Workforce Service (DWS) to obtain information from other state agencies and other sources to confirm the accuracy of my statements.
- I understand that as a condition of eligibility, each applicant for or recipient of Work Pays benefits must furnish his/her social security number to DHHS. Federal law 42U.S.C. §§ 1320b-7(a) (1) and 1320b-7(b) (2) and DHHS Transitional Employment Assistance Manual Policy 2110 make DHHS collect your SSN before approving your application. * Disclosure of your Social Security Number is voluntary. However, a person who does not provide the number or apply for one will not be eligible to receive benefits. If someone does not have an SSN, DHHS will help the person apply for one. As long as an SSN application is filed with the Social Security Office, the DHHS application may be approved. DHHS will also use Social Security Numbers for program applicants and participants to access information, determine eligibility, verify wages, unearned income and other information, to prevent duplicate participation, to facilitate mass changes in Federal benefits and to determine the accuracy and reliability of information.
- I understand that no person may be denied Work Pays benefits on the grounds of race, color, sex, age, disability, religion, national origin, or political belief.
- I may request a hearing from DHHS if a decision is not made on my case within the proper time limit or if I disagree with the decision.
- I agree to notify my case manager within 10 days if I or any of my dependents cease to live in my home, if I move, or if any other changes occur in my circumstances.
- I authorize DHHS to examine all records of mine or records of those who receive or have received Work Pays benefits through me to investigate whether or not any person has committed fraud, or for use in any legal, administrative or judicial proceeding.

Assignment of Child Support. I understand that if I accept Work Pays, by state law, I will **have** assigned all rights, title, and interest in any support that I have in my own behalf or in behalf of any other person for whom I am receiving a Work Pay payment. I understand that all support payments including those received by me directly from the absent parent, are to be paid to the Office of Child Support Enforcement. I understand that this assignment ends when I no longer receive Work Pays except as to any unpaid support obligation that has accrued at the time my Work Pays case is closed. I also understand that as a condition of eligibility for Work Pays, I must cooperate with the Office of Child Support Enforcement in establishing paternity and obtaining child support.

I DECLARE UNDER PENALTY OF PERJURY THAT THE ABOVE IS TRUE AND CORRECT. If I receive benefits to which I am not entitled because I withheld information or provided inaccurate information, such assistance will be subject to recovery by the Department of Health and Human Services, and I may be subject to prosecution for fraud and fined and/or imprisoned.

_____ _____
Signature of Parent or Relative Date Telephone number of person helping to complete form

_____ _____
Signature of Second Parent Date

_____ _____
Signature of Family Support Specialist Date Address of person helping to complete form

A decision on your application should be made within 30 days.

If you have questions about eligibility for Work Pays, call your TEA case manager.

Please fold and return the Application to the address shown on the back

Fold in half, tape ends together, and mail to the address listed below.

Return Address

_____

_____

_____

Place
Stamp
Here